Claire Ellison Counseling

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form. No responsibility can be accepted if it is made available to any other person or agency. Any duplication, transmittal, re-disclosure, or retransfer of information is expressly prohibited.

I, ________________________, authorize Claire Ellison, M.Ed., LPC, RPT to release/exchange by phone, fax or mail the PHI from the client record(s) of:

____ ______________________

Last First Middle Date of Birth

with: ____

____

(Name/Address of person/organization to which disclosure is to be made)

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

I, the undersigned, understand that a copy of this signed authorization form is as acceptable as the original.

The protected health information to be disclosed includes the following:

____ Assessment information
____ Diagnosis
____ Treatment Planning Information
____ Progress & Treatment Notes
____ Communicable Disease Information
____ Medication
____ Psychiatric Evaluation
____ Results of Psychological Testing
____ Recommendations
____ Reason for Termination
____ Number of kept/un-kept appointments
____ Results of Clinical Polygraphs

Other (please specify): ____

For the purpose of: Continued Care; Education; Legal; Insurance; Collaboration; Other: ___________________

Dates of records to be released: __________________
From-To

This release will expire: ____ at the end of 60 days
____ at the termination of treatment
____ as of ____________________
(Specify date)

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

__________________________ ______________________________________ __________________

Client signature Parent/Guardian/legal representative signature Date

__________________________ __________________

Witness signature Date

11999 Katy Freeway, Suite 530
Houston, TX 77079
281-622-9884 (p)
281-605-1922 (f)